STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155664	A. BUILDING _____ B. WING _____	C 11/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	4102 SHORE DR INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00119130 Complaint IN00119130: Unsubstantiated, due to lack of evidence. Surveyor Dates: November 13, 14, 15, 16, 19, 20, & 21, 2012 Facility Number: 010666 Provider Number: 155664 AIM Number: 200229930 Survey Team: Patti Allen, BSW, TC Marcy Smith, RN (November 15, 16, 19, 20, & 21, 2012) Leia Alley, RN Dinah Jones, RN Census Bed Type: SNF/NF: 100 Total: 100 Census Payor Type: Medicare: 33 Medicaid: 42 Other: 25 Total: 100 Kindred Transitional Care and Rehab Eagle Creek Facility was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 with regard to the Recertification, State Licensure Survey and Investigation of Complaint IN00119130.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality review completed on November 27, 2012 by Bev Faulkner, RN	F 000		